Group Dental Reimbursement Claim Form

Insured and/or Administered by
Connecticut General Life Insurance Company

CIGNA HealthCare

CIGNA

MAIL THIS FORM TO: CIGNA HealthCare Service Center
P.O. Box 15558
Wilmington, DE 19850-5558

ARGONNE NATIONAL LABORATORY

1-800-441-7150 Toll Free
(302) 323-1717 Local Calls

DO NOT USE STAPLES

PART I - TO BE COMPLETED BY EMPLOYEE

1. PATIENT NAME	2. RELATIONSHIP TO EMPLOYEE Self ☐ Spouse ☐ Child ☐ Other ☐	3. SEX M ☐ F ☐	4. PATIENT BIRTH DATE Mo. Day Year	5. IF FULL TIME STUDENT School City
6. EMPLOYEE / MEMBER / SUBSCRIBER NAME *(First, Middle, Last)*			7. EMPLOYEE SOCIAL SECURITY NO.	EMPLOYEE BIRTH DATE Mo. Day Year
8. EMPLOYEE MAILING ADDRESS CITY, STATE, ZIP			9. COMPANY (EMPLOYER) NAME AND ADDRESS AND/OR DIVISION AND PLANT LOCATION ARGONNE NATIONAL LABORATORY	
10. ACCOUNT / POLICY # 0220668	11. IS SPOUSE OR OTHER FAMILY MEMBER EMPLOYED? ☐ Yes ☐ No *If yes, Member's Name* SOCIAL SECURITY NO.		12. NAME AND ADDRESS OF SPOUSE'S OR OTHER FAMILY MEMBER'S EMPLOYER IN ITEM 11	SPOUSE BIRTH DATE Mo. Day Year
13. IS PATIENT COVERED BY ANOTHER DENTAL PLAN? ☐ Yes ☐ No *If yes, indicate*	DENTAL PLAN NAME	GROUP NO.	NAME AND ADDRESS OF CARRIER	

AUTHORIZATION TO RELEASE INFORMATION - I hereby authorize any Provider, Insurer or other Organization to release any information regarding the dental history, treatment, or benefits payable for this claim to the Plan Administrator or its authorized agent for the purpose of determining benefits payable. This authorization or a copy shall be valid for one year from the date of signature. — SIGNED (PATIENT OR PARENT IF MINOR) — DATE

AUTHORIZATION TO PAY BENEFITS TO DENTIST - I hereby authorize payment directly to the below named Dentist of the Dental Benefits otherwise payable to me. — SIGNED (EMPLOYEE) — DATE

CERTIFICATION - I certify that the foregoing information is true and correct. — SIGNED (EMPLOYEE) — DATE

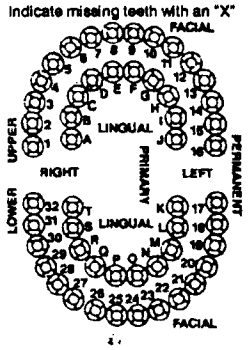
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES A STATEMENT CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS, FOR THE PURPOSE OF MISLEADING INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT WHICH IS A CRIME

PART II - TO BE COMPLETED BY ATTENDING DENTIST

14. DENTIST NAME		22. IS TREATMENT RESULT OF OCCUPATIONAL ILLNESS OR INJURY?	NO ☐	YES ☐	IF YES, ENTER BRIEF DESCRIPTION AND DATES
15. MAILING ADDRESS CITY, STATE, ZIP		23. IS TREATMENT RESULT OF AUTO ACCIDENT?	☐	☐	
		24. OTHER ACCIDENT?	☐	☐	
		25. ARE ANY SERVICES COVERED BY ANOTHER PLAN?	☐	☐	IF YES, NAME OF OTHER PLAN:
16. TAX I.D. # TO BE USED FOR TAX REPORTING. TAX I.D. #	SOC. SEC. #	26. IF PROSTHESIS, IS THIS INITIAL PLACEMENT?	☐	☐	(IF NO, REASON FOR REPLACEMENT) — 27. DATE OF PRIOR PLACEMENT
17. DENTIST LICENSE NO.	18. DENTIST PHONE NO.				
19. FIRST VISIT DATE CURRENT SERIES	20. PLACE OF TREATMENT Office ☐ Hosp. ☐ ECF ☐ Other ☐	21. RADIOGRAPHS OR MODELS ENCLOSED? ☐ Yes ☐ No — HOW MANY?		28. IS TREATMENT FOR ORTHODONTICS?	☐ ☐ — IF SERVICES ALREADY COMMENCED, ENTER DATE APPLIANCES PLACED — MOS. TREATMENT REMAINING

CHECK ONE:
☐ PREDETERMINATION OF BENEFITS
☐ Statement of Actual Services

Indicate missing teeth with an "X"



29. EXAMINATION AND TREATMENT PLAN-LIST IN ORDER FROM TOOTH NO. 1 THROUGH TOOTH NO. 32-USE CHARTING SYSTEM SHOWN

TOOTH # OR LETTER	SURFACE (i.e., M, O, D, B, L, LA, I)	DESCRIPTION OF SERVICE *(Including X-Rays, Prophylaxis, Materials Used, Etc.)*	DATE SERVICE COMPLETED Mo. Day Year	PROCEDURE NUMBER *(See Reverse)*	FEE

30. Remarks for unusual services

I HEREBY CERTIFY THAT THE PROCEDURES AS INDICATED BY DATE HAVE BEEN COMPLETED AND THE FEES INDICATED ARE THOSE ACTUALLY CHARGED THE PATIENT REGARDLESS OF THE EXISTENCE OF INSURANCE COVERAGE. — SIGNED (DENTIST) — DATE — TOTAL FEE CHARGED

INSTRUCTIONS

FOR THE EMPLOYEE

1. Please answer all questions in Part I entitled "TO BE COMPLETED BY EMPLOYEE".
2. Sign and Date the "Authorization to Release Information".
3. If you wish to have your benefits paid directly to the Dentist, sign and date the "Authorization to pay Benefits to Dentist".

   If authorized, payment will be made directly to your Dentist. A copy of the payment will be sent to you for your records. Otherwise, payment will be made directly to you.
4. If the patient has coverage under any other group or Government plan, submit the same bills to the other plan at the same time.
5. If you participate in your employer's Healthcare Reimbursement Account administered by Connecticut General and you want unpaid expenses submitted to the Reimbursement Account for consideration, see below.

FOR THE DENTIST

For claims involving Predetermination of Benefits:

1. Complete the section "TO BE COMPLETED BY ATTENDING DENTIST". Be sure to itemize charges for each proposed procedure.
2. CIGNA HealthCare will review the treatment plan and will provide the estimate of benefits payable.
3. Review the form and benefit estimates with your patient before the work is done.
4. When you complete treatment, return the form with the treatment dates completed and your signature.

For claims not involving Predetermination of Benefits:

1. Complete Part II. Be sure to date and itemize charges.
2. Sign and date bottom of claim form when work is completed.

PLEASE NOTE: IF THE CLAIM FORM IS NOT COMPLETED IN FULL AND SERVICES ARE NOT COMPLETELY ITEMIZED, PROCESSING OF PAYMENT WILL BE DELAYED UNTIL ALL REQUIRED INFORMATION HAS BEEN SUBMITTED.

The following supportive documentation, as indicated below, may be necessary to determine benefits:

A. Pre-operative X-rays and/or Narrative

- Gold Inlay Restoration
- Crowns - Single Restorations
- Root Canal Therapy
- Dentures - Partial
- Bridges - Pontics, Abutments, and Inlays
- Oral Surgery

B. Periodontal Case Type and Pocket Depth Chart

- Scaling and Root Planing
- Gingivectomy / Gingivoplasty
- Curettage
- Periodontal Surgery - Osseous, Mucogingival

C. Narrative

- Space Maintainers
- Dentures - Full
- Alveoplasty
- Grafts
- Anesthesia

REIMBURSEMENT ACCOUNT CLAIM CERTIFICATION:

Complete Only if you are a Reimbursement Account Participant

If you participate in a Healthcare Reimbursement Account, do you want unpaid amounts from the attached expenses submitted to your Reimbursement Account for reimbursement?

☐ YES ☐ NO

A. If requesting reimbursement of expenses from a Healthcare Reimbursement Account, I certify that I or my eligible dependents have incurred these expenses and that these expenses have not been reimbursed from any other source, nor do I expect them to be. I agree to notify the Plan Administrator immediately in the event any of these expenses are reimbursed from another source.

B. I understand that if I or my eligible dependents have benefits under another plan, I must submit the attached expenses to the other plan for payment and provide proof of denial before the expenses will be considered for reimbursement from my Reimbursement Account.

SIGNATURE	DATE